TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-17-2643-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
May 08, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a formal request for reconsideration of payment for services render to above referenced patient.

According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount … there is a pending payment in the amount of $2,387.90."

Amount in Dispute: $4,961.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are in receipt of the MDR request from DWC for Doctors Hospital at Renaissance, date of service 8/25/16, on the above mentioned claim.

ESIS Med Bill impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $4,961.84."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 22, 2016 to August 25, 2016	Outpatient Hospital Services	$4,961.84	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 3 – NATIONAL CORRECT CODING INITIATIVE EDIT – EITHER MUTUALLY EXCLUSIVE OF OR INTEGRAL TO ANOTHER SERVICE PERFORMED ON THE SAME DAY
    - 4 – CMS OPPS STVX – PACKAGED SERVICE IS PACKAGED INTO THE PAYMENT FOR THE SERVICES WITH STATUS INDICATOR S, T, V OR X AND NO SEPARATE PAYMENT IS MADE FOR THE STVX – PACKAGED SERVICES
    - 8 236 – THIS PROCEDURE OR PROCEDURE/MODIFIER COMBINATION IS NOT COMPENSABLE WITH ANOTHER PROCEDURE OR PROCEDURE/MODIFIER
    - 9 97 – THE BENEFIT FOR THIS SERVIC E IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED
    - 11 – A TECHNICAL BILL REVIEW (TBR) HAS BEEN PERFORMED
    - 11 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINDED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME
    - 13 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED
    - 16 – THIS APPEAL IS DENIED AS WE FIND THE ORIGINAL REVIEWE REFLECTED THE APPROPRIATE ALLOWANCE FOR THE SERVICE RENDERED. WE FIND THAT NO ADDITIONAL RECOMMENDATION IS WARRANTED AT THIS TIME
    - 1 – DCN 9636207
    - 2 – THIS PRCOEDURE ON THIS DATE WAS PREVIOUSLY REVIEWED
    - 3 18 – DUPLICATE CLAIM/SERVICE
    - 4 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRS TIME
    - 5 – THIS APPEAL IS DENIED AS WE FIND SERVICE RENDERED. WE FIND THAT NO ADDITIONAL RECOMMENDATION IS WARRANTED AT THIS TIME

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment for the services in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute regards outpatient hospital services with reimbursement subject to the division's *Hospital Facility Fee Guideline—Outpatient*, at 28 Texas Administrative Code §134.403, which requires the maximum allowable reimbursement (MAR) be calculated using the Medicare facility specific amount (including outlier payments) as determined by the applicable Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors, published annually in the Federal Register, with modifications as set forth in the rules.

   Rule §134.403(f)(1) requires that the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent, unless a facility or surgical implant provider requests separate payment of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and for services without procedure codes is packaged into the APC payment. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

    - Procedure code 36415, service date August 22, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.

- Procedure code 80053, service date August 22, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 82962 has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 82962 has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85027, service date August 22, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85610, service date August 22, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 85730, service date August 22, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 81001, service date August 22, 2016, has status indicator Q4, denoting packaged labs; reimbursement is included in APC payment for primary services. Not separately paid unless bill contains only status Q4 HCPCS codes listed in the Clinical Lab Fee Schedule.
- Procedure code 29881 has status indicator T, denoting significant outpatient procedures subject to multiple-procedure reduction. The highest paying status T unit is paid at 100%; all others at 50%. This procedure is paid at 100%. This is assigned APC 5122. The OPPS Addendum A rate is $2,395.59. This is multiplied by 60% for an unadjusted labor-related amount of $1,437.35, which is multiplied by the facility wage index of 0.7989 for an adjusted labor amount of $1,148.30. The non-labor related portion is 40% of the APC rate, or $958.24. The sum of the labor and non-labor portions is $2,106.54. The cost of these services does not exceed the fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific amount of $2,106.54 is multiplied by 200% for a MAR of $4,213.08.
- Procedure code 31720 has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for any procedures with status indicator S, T or V. These services are separately payable only if no other such procedures are billed.
- Procedure code 94664 has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for any procedures with status indicator S, T or V. These services are separately payable only if no other such procedures are billed.
- Procedure code 94640 has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for any procedures with status indicator S, T or V. These services are separately payable only if no other such procedures are billed.
- Procedure code 94640 has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for any procedures with status indicator S, T or V. These services are separately payable only if no other such procedures are billed.
- Procedure code 94770 has status indicator S, denoting significant outpatient procedures paid by APC, not subject to reduction. This is assigned APC 5722. The OPPS Addendum A rate is $220.35. This is multiplied by 60% for an unadjusted labor-related amount of $132.21, which is multiplied by the facility wage index of 0.7989 for an adjusted labor amount of $105.62. The non-labor related portion is 40% of the APC rate, or $88.14. The sum of the labor and non-labor portions is $193.76. The cost of

these services does not exceed the fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific amount of $193.76 is multiplied by 200% for a MAR of $387.52.

- Procedure code 94760 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J1885 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J0171 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J2250 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J2405 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J3301 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J0690 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J2001 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J3010 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J2765 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code J2270 has status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement is included in the payment for the primary services.
- Procedure code A9270 has status indicator E, denoting excluded or non-covered codes not payable on an outpatient bill. Payment is not recommended.
- Procedure code 93005, service date August 22, 2016, has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for any procedures with status indicator S, T or V. These services are separately payable only if no other such procedures are billed.
- Procedure code 51798 has status indicator Q1, denoting STV-packaged codes; reimbursement for these services is packaged with the payment for any procedures with status indicator S, T or V. These services are separately payable only if no other such procedures are billed.

4. The total recommended reimbursement for the disputed services is $4,600.60. The insurance carrier has paid $4,961.84 leaving an amount due to the requestor of $0.00. Additional payment is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		6/9/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.